Training for Burnout?

THE issue of physician wellness, which has been of interest to medical educators, has now drawn the attention of the media and the public. Efforts to assess and address this issue could be significantly more effective if they were expanded to involve physicians in community practice. Enhanced peer interaction, including peer support and counseling, may be a potent tool for prevention and management of some of the stressors related to clinical practice.

Introduction

In the past year, I have become increasingly concerned about the message the public has been receiving from the press and other media regarding physician health.

In "Checking Up on the Doctor" (5/25/10), the *Wall Street Journal* examined how physicians tend to manage their own care. Citing surveys and polls, the article offered readers "some clues—and some surprises" on physician stress, self-prescribing and suicide.

"As Doctors Age, Worries About Their Ability Grow" raised related questions in an article published earlier this year in the *New York Times* (1/25/11). *US News* also headlined, "Medical Students More Depressed Than General Population" (1/30/09), citing the striking prevalence of depression and burnout among doctors-to-be. Each of these articles carried an underlying cautionary message: "Patient beware."

For this reason, I was particularly struck by the recent paper, "Suicidal Ideation Among American Surgeons."[1] This study found that as many as one in 16 American surgeons had considered suicide. This incidence is 1.5 to 3.0 times higher than in the general population. Within days following this startling paper, CBS News, Reuters and the Associated Press weighed in with their own theories on whether it was "stress," "medical errors" or "reluctance to seek help" that could be to blame.[2]

My immediate reaction, I readily admit, centered on the public perception—the potential reaction among patients who would be reading these accounts. I envisioned patients nationwide postponing needed surgical procedures until they could personally check on the well-being of their surgeons. Fortunately, of course, this situation never materialized. However, important questions still remain. First, does this represent a real phenomenon among our medical and surgical colleagues? Second, should there be cause for concern?

Scope of Problem—Trainees

It is well recognized that depression and burnout are common during medical training.[3,4] Longitudinal studies show a prevalence of depression as high as 25%, and burnout as high as 49.6%, among students at U.S. medical schools.[3] Twelve point six percent of these students also reported having had suicidal thoughts. Heavy workload, pervasive stress and sleep deprivation have all been cited among possible causes. However, there are those who still view these factors as being necessary rites of passage in preparation for the demands of medical practice.

There are also certain personality traits that may be more prevalent among students who choose the field of medicine; some of these traits may render them more susceptible to burnout. Altruism, competitiveness, responsibility, compassion and low tolerance for uncertainty or failure are traits that could predispose to burnout given the right circumstances. Unfortunately, those are the very circumstances that are prevalent in our training programs: long hours, stress, clinical uncertainty and an overdeveloped sense of personal responsibility and accountability among some of our younger trainees.

Another important risk-factor may be the "iron man" mentality that is prevalent in most medical schools and training programs. This is the ethos that reinforces self-sufficiency, stoicism and self-denial while discouraging vulnerability, sensitivity or any expression of uncertainty. Some medical schools and teaching hospitals have begun to address this problem with peer support programs and curriculum material that explores issues of stress management and life balance. These efforts might also provide a model that could be useful for physicians who are out of training and farther along in their professional careers.

Scope of the Problem—Physicians in Practice

Even following their formal training, doctors continue to face challenges of clinical uncertainty, long hours and a variety of stressors ranging from threat of malpractice, to loss of autonomy, to dramatic changes in the health-care environment. One unfortunate indicator of this ongoing stress may be the striking incidence of suicide

among physicians. Male physicians have a 1.7 times greater risk of suicide than male professionals who work in other fields.[5] For female physicians, the risk is actually 2.5 to 5.7 times higher than for other women.[6,7] On an annual basis, we lose approximately 400 physicians to suicide in the US.[8] This has been compared to the loss of two entire medical school graduating classes each year.[8] Beyond these deaths, there certainly exists a significant and unreported burden of distress, anxiety and depression among our physician peers.

Too often, when a physician experiences distress, he or she may suffer in isolation.[1] As the common setting for much of our work, today's hospital is a highly social and political organization with its own complex allegiances and long-standing relationships. Hospital staffs work in close coordination, often over a period of years, and come to value conformity and reliability. In this setting, news can travel very quickly. A physician's impulse to share a personal problem with a colleague frequently has to be weighed against this reality.

The image of professional competence and reputation are key concerns for practicing physicians. There may be a degree of risk in sharing matters of a personal nature, even with close colleagues. Feelings of distress may well inhibit an individual's sharing with colleagues. This reluctance to communicate can foster isolation and can lead to even further distress.

This may be where some of the peer support concepts from the medical schools and teaching hospitals could be of real help. An informal discussion group or peer forum could play an important role in re-establishing vital communication among colleagues. There are issues ranging from malpractice, reimbursement, burnout, managed care to loss of professional autonomy that could be potential starting points for meaningful discussion. Additional and related topics have also been raised in a new AMA publication, "Physician Health e-Letter", which focuses on physician health, stress and wellness.[9]

Whatever the topics, these discussions would ideally be pursued in a forum separate and apart from the regular business of the medical staff or the peer review activities of the hospital. The participants must feel comfortable and have the sense that they are in an environment where they can express themselves freely. There have been instances where the hospital peer review process has been used to marginalize certain individuals who had been viewed as "outliers" in some respect.[10] The voluntary and confidential nature of these peer discussions needs to be emphasized and reinforced in order to facilitate the broadest possible participation. In this way, many of the wellness initiatives in use at medical schools could be extended to physicians in clinical practice.

Conclusion

Enhanced peer interactions are needed both to prevent and to manage some of the stress-related problems associated with clinical practice.

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